Making Strides LLC
megan@makingstridesmi.com
ph: (989)284-6670
fax: (231)386-7298

PHYSICIAN RELEASE FORM

Your Patient, _____, DOB _____, is interested in participating in occupational therapy utilizing hippotherapy (movement of the horse) as part of a comprehensive treatment plan or in adaptive riding lessons.

Precautions and contraindications for mounted activities:

The following conditions in the table below may suggest precautions and contraindications to therapy using a horse or other mounted activities (e.g adaptive riding). Please check any conditions that are present and to what degree:

ORTHOPEDIC

- ☐ Atlantoaxial Instability (include neurologic symptoms)*
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ Heterotopic Ossification/ Myositis Ossificans
- ☐ Joint subluxation/ dislocation
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Spinal Fusion/ Fixation
- ☐ Spinal Instability/ Abnormalities

NEUROLOGIC

- ☐ Hydrocephalus/ Shunt
- ☐ Seizure
- ☐ Spina Bifida/ Chiari II Malformation
- ☐ Tethered Cord/ Hydromyelia

OTHER

- ☐ Age – under 3 years
- ☐ Indwelling Catheters
- ☐ Medications – (i.e. photosensitivity)
- ☐ Poor Endurance
- ☐ Skin Breakdown

MEDICAL/ PSYCHOLOGICAL

- ☐ Allergies
- ☐ Animal Abuse
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Blood Pressure Control
- ☐ Dangerous to self or others
- ☐ Exacerbations of medical conditions
- ☐ Fire Setting
- ☐ Heart Conditions
- ☐ Hemophilia
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Respiratory Compromise
- ☐ Recent Surgeries
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorders

***Participants with Down Syndrome must provide results of a negative diagnostic x-ray for atlantoaxial instability / dislocation condition.*

☐ I **DO give permission** to participate in mounted equine assisted activities and therapies.
☐ I **DO NOT give permission** to participate in mounted equine activities or therapies

Physician's Signature_____ Date _____

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PHYSICIAN'S PRESCRIPTION

Patient's Name: _____

Date of Birth: _____

Diagnosis and ICD 10 Codes: _____

Date of Onset: _____

Additional Notes: _____

☐ **Occupational Therapy is prescribed for evaluation and treatment emphasizing but not limited to:**

_____

Physician Signature: _____ **Date:** _____

Printed Name: _____

NPI: _____

Address: _____

_____

Phone: _____ **Fax:** _____